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ABSTRACT

Many mentally ill children, especially those who are seriously disturbed, are not receiving the mental health care they need. Although the federal government offers financing to the states for child and adolescent mental health programming, the primary responsibility for financing mental health services has been assumed by state governments. At the local level reimbursement systems and the economic climate have served as fiscal disincentives to continued development of community-based programs for this group. The reality of mental health care for children and adolescents has historically been one of disorganization, lack of coordination, and an overemphasis on unnecessarily restrictive treatment programs. Barriers to delivering appropriate services to children include definitional ambiguity; service fragmentation; economic disincentives; crisis orientation; and lack of advocacy. The continuum care mode for children should include the components of prevention, non-residential, and residential services. Although children's mental health services have improved dramatically, these systems continue to have major gaps and barriers. State legislatures and other governmental bodies, foundations and other private sector institutions, and mental health systems are attempting to produce positive changes. Despite this progress, much remains to be done. Policymakers should focus on developing a continuum of care, coordinating and integrating the delivery system, and involving families in the treatment process. (Specific program and legislative responses of the states are described.) (ABL)

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MENTAL HEALTH PROJECT

Human Services Series

Mental Health Services for Children and Youth: Strengthening the Promise of the Future

by

Rebecca Craig

Vol. 13, No. 25 Updated September 1988

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MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH: STRENGTHENING THE PROMISE OF THE FUTURE

INTRODUCTION

- Judy has been experiencing difficulties in school for several years. Now 12, she is generally depressed and maintains poor relationships with her peers. After hitting a school teacher a year ago, Judy has been in and out of residential placements and psychiatric hospitals. The system has alternately overprotected and rejected her.

- Ross, a 14-year-old boy, has been picked up by the police for possession of a controlled substance and for breaking and entering. At school he is disruptive and frequently acts out. Although he has received inpatient care on several occasions, Ross always returns to an abusive home environment without any case management or follow-up services.

- Melissa was diagnosed as being severely emotionally disturbed three months ago. Although her father's insurance will pay for some treatment, the closest facility is 200 miles away and covered treatment is limited to 90 days.

According to Jane Knitzer, author of Unclaimed Children (1, p. ix), of the nation's three million children who are seriously disturbed in this country, two-thirds are not receiving the services they need, while untold others receive inappropriate care. Furthermore, children who are the most disturbed may often be the least likely to get help. These children are "unclaimed" by the public agencies with the responsibility to serve them.

Together, the stories of children like Judy, Ross and Melissa add up to a major public health crisis, the gravity of which is illustrated by the following statistics, compiled by the National Institute of Mental Health and by the Institute of Medicine:

- 99,850 children and adolescents, 17 years of age or under, underwent psychiatric hospitalization in state, county and private mental hospitals and in non-federal general hospitals during 1980 (2).

- An additional 350,000 received outpatient services in psychiatric clinics during 1975 (3) and evidence indicates that this number has increased in recent years.

- 86 percent of children and youth receiving treatment in residential facilities for substance abuse were reported to have some degree of concurrent emotional disturbance or behavior disorder (2).

- The suicide rate for youths 15 to 24 years of age has increased from five in 100,000 in 1961 to 13 in 100,000 in 1983--a 150 percent increase (4, p. 5).

- The National Institute of Alcohol Abuse and Alcoholism estimates that three million of our youths are problem drinkers. Of the 25,000 to 28,000 traffic fatalities in this country each year, at least 10,000 are young Americans between the ages of 15 and 24 (5, p.2).

- Mental disorders and addictions rank third in personal health expenditures, one major indicator of social costs (4, p. 5).

THE IMPACT OF FEDERAL AND STATE INITIATIVES

Federal and state governments, in addition to many national organizations, have recognized the critical need to improve systems of care for children and adolescents and to find new ways to generate funds and support for these programs. At present, the federal government offers financing to the states for child and adolescent mental health programming under Title XIX of the Social Security Act via Medicaid and through grants to states for a wide range of mental health efforts under Title XX. However, federal support for children and youth mental health services declined 8 percent between 1981 and 1983 and continues to decline, given budget restraints (6, p. 10).

The primary responsibility for financing mental health services to children has been assumed by state governments, with an estimated $1.06 billion spent nationally in 1983 (6, p. 1). However, economic belt-tightening has forced many states to find the means to raise taxes and reduce spending. Increased Medicaid costs have increased the required local Medicaid contribution in many states. The effect has been to cause many states to relieve local governments of this "fiscal burden" by assuming the cost for certain programs, leaving fewer dollars for less restrictive children and youth mental health services.

At the local level, reimbursement systems and the economic climate have served as "fiscal disincentives" to continued development of community-based programs for children and young people with mental illness as well as other disabled groups. These factors have also reinforced communities' inclination to place more youths with emotional problems in unnecessarily restrictive settings outside the community. Subsequently, a disproportionate share of future funding expenditures on traditional state residential care has been spurred at the expense of community-based care.

In 1984 Congress mandated the Child and Adolescent Service System Program (CASSP) in an effort to focus attention on children's mental health problems. One and a half million dollars was targeted to develop a new initiative to improve service delivery and ensure a comprehensive, coordinated system of care. CASSP provides grant support to state mental health agencies or to the state children's agency that has primary responsibility for children's mental health services. Through this type of initiative, the federal government can serve as a catalyst in the development of children's mental health services, while the major responsibility for providing mental health services remains with the states.

SYSTEM OF CARE: CONFUSION, GAPS AND BARRIERS

The reality of mental health programs for children and adolescents historically has been one of disorganization, lack of coordination and an overemphasis on unnecessarily restrictive treatment programs. The delivery system for children and youth involves not only the mental health system, but also vocational rehabilitation, substance abuse and mental retardation programs, as well as key agencies such as education, health, child welfare and juvenile justice. Numerous possibilities exist for agency turf battles and coordination problems. Additionally, there has been a sizable gap between what is known about effective practices for serving emotionally disturbed children and use of that knowledge.

Since currently 50 to 80 percent of children and adolescents with serious mental illness do retain their disability into adult life, the lack of appropriate treatment and services for this population is having a tremendous impact on future costs of mental illness to the public.

In comparing existing mental health services for children and youth, and in studying the results of research on program effectiveness, Dr. Robert Friedman of the Florida Mental Health Institute identified the following problem areas which present barriers in delivering appropriate services to children (8, pp.16-32):

- Definitional Ambiguity. Diagnosing children and adolescents suffering from mental illness is generally determined by the process of "clinical judgment," often characterized by a lack of clarity in the separation of those youths with a serious mental illness from those with other developmental disabilities.

- Lack of Options in Models of Service Delivery. The concept of a "continuum of care" revolves around the need for a wide range of available services to encompass the corresponding wide range of needs. In the absence of such a continuum of care, children tend to end up in more restrictive settings than might be otherwise warranted.

- Diffuse Accountability for Services. In spite of mandates for the educational system to assume responsibility for education and related services to handicapped children, "under-identification" of these youths remains a problem. A "pass the buck" syndrome is also common, wherein the child is passed back and forth within the various systems, with each system declining responsibility.

- Use of Inappropriate Treatment Models and Techniques. Mental health treatment for children has been modeled after adult treatment techniques, which do not work well with children who are seriously disturbed.

- Service Fragmentation. Children and youth with serious and complex problems receive services in an uncoordinated and piecemeal fashion, if at all.

- Service Barriers. Due to funding, age and other requirements, eligibility and service provision criteria often interfere with providing early intervention, continued care and appropriate services.

- Absence of Trained Professionals. Most teachers, psychologists, psychiatrists, social workers and other professionals have little if any specialized training in working with children who are emotionally disturbed.

- Economic Disincentives. Over two-thirds of state mental health agency funds go for residential care. Day treatment is not usually reimbursable with federal dollars. Third-party payments tend to cover only certain services for limited periods. Because of these disincentives, restrictive and inappropriate services are often relied upon.

- Crisis Orientation. Most funding and planning for mental health programs have been short-term and oriented towards the "crisis of the moment." Planning for future needs, early intervention and community-based programming is urgently needed.

- Lack of Advocacy. Although some states have begun to focus on children and youth issues, far too many lack a state-level focus and the needed interest and leadership to advocate effectively for the mental health of children.

GENERAL LEGISLATIVE GUIDELINES

To respond to the varied and often complex needs of children who are emotionally disturbed, states should consider establishing a continuum of care for children's mental health services. The continuum of care model for children should include three components (8, pp. 8-14):

- Prevention Services. These services attempt to reduce the incidence of emotional problems in children through promoting positive mental health, attempting to modify the impact of systems or institutions that affect an individual's mental health, and educating the public about mental illness. Early intervention is particularly important in working with youths.

- Non-Residential Services. This broad category generally involves diagnosis and evaluation, outpatient treatment and crisis counseling, and day treatment.

- Residential Services. This component is made up of therapeutic foster care, therapeutic group homes, residential treatment centers and inpatient programs. State hospital programs for children serve as the final back-up when other alternatives prove unsucccessful.

States should also acknowledge the problems encountered by children within the mental health system and attempt to improve service delivery. According to Dr. Friedman, children's mental health services should be (8, pp. 5-8):

- Multi-system, involving all available agencies in planning and working together on behalf of these youths.

- Provided in the least restrictive setting possible. Many studies have shown a tendency to overestimate the amount of restriction actually needed.

- Family-based, closely involving family memebers in the treatment process. Studies indicate that the majority of adolescents successful in reentering the community came from homes with at least one natural parent while the majority of reinstitutionalized adolescents were in custody of a human service agency.

- Carefully planned at the state and local levels, with the emphasis placed on each community's resources, needs, priorities and weaknesses.

- Community-based. Studies reveal that the major factors in determining the long-term outcome for residential clients are not related to the type and severity of psychopathology but to the post-discharge resources available to the youth. Community-based systems of services are more effective, more cost-efficient and more humane. Fiscal incentives must be provided for community systems. It would behoove federal and state programs to reflect this knowledge in a concrete manner by funding more community-based programs.

- Balanced. Service delivery systems need to strike a better balance between prevention and early intervention programs and more expensive, restrictive residential services programs.

- Accessible, timely and of sufficient intensity. Intensive outreach programs are often the most effective means of treatment and frequently help avert hospitalization.

- Oriented towards early intervention. Most experts agree that money spent today in education and good prevention programming saves in treatment costs later on. Especially important are programs for children of alcholics as it is standard for these youths to exhibit subsequent problems.

THE STATES' RESPONSE IN RECENT YEARS

Increased recognition of the problems facing mentally ill children and adolescents, as well as an expanded emphasis on resolving these problems, has produced a ground swell of legislation in this area. Summaries of legislation enacted prior to 1986 outlined below were largely excerpted from State Legislation Affecting the Delivery of Mental Health Services to Children and Youth (9).

Comprehensive Service Efforts. At least 14 states, California (1987 Cal. Stats., Chap. 1361), Connecticut (Conn. Gen. Stat. § 17.410 - 17.447), Delaware (Vol. 64, 1983 Del. Laws,

Chap. 108,), Hawaii (1974 Hawaii Sess. Laws, Act 210), Illinois (1987 Ill. Laws, P.A. 85-816), Maine (1987 Me. Laws, Chap. 181), Michigan (1984 Mich. Pub. Acts, Act 186), Montana (1987 Mont. Laws, Chap. 447), New Hampshire (1983 N.H. Laws, Chap. 416), North Carolina (1987 N.C. Sess. Laws, Chap. 830), North Dakota (1987 N.D. Sess. Laws, Chap. 185), Rhode Island (1979 R.I. Pub. Laws, Chap. 248) South Carolina (1986 S.C. Acts, Act 421 and Act 431) and Washington (1983 Wash. Laws, Chap. 192) have taken definitive legislative steps to address the mental health needs of minors, either through consolidating service delivery efforts or through mandating a comprehensive service delivery system. In 1987, California enacted the Children's Mental Health Services Act to establish a comprehensive and coordinated children's mental health system. North Carolina appropriated funds to develop, over a 10-year period, a comprehensive system of care for children and adolescents with mental health problems. Maine established, in statute, the interdepartmental committee to coordinate services for children and families. The committee has existed since 1978. North Dakota established a Children's Services Coordinating Committee to develop and implement a plan for the coordinated delivery of services to children and adolescents, including those with mental health problems. In recent years, Michigan created a new section of the Michigan Code focusing on services to emotionally disturbed children and youth, establishing a single port of entry/exit system, and authorizing the development of children's diagnostic and treatment services within the community mental health centers. During the 1986 session, South Carolina (Act 431) permanently authorized the Continuum of Care for Emotionally Disturbed Children, and also set up the Children's Case Resolution System (Act 421) to resolve individual case problems with gaps in service delivery.

A number of states have taken preliminary steps toward a comprehensive service delivery system for minors. To begin with, at least 10 states have established study commissions or committees, including Delaware, Maryland, Massachusetts, Missouri, Nebraska, New Jersey, Oklahoma, Tennessee, Virginia and Washington. In 1987, New Jersey (1987 N.J. Laws, S.J.R. 36) established a task force on coordination of programs for children by community volunteer groups, and Oklahoma (1987 Okla. Sess. Laws, H.J.R. 1021) requested a study of state-sponsored delivery systems to children and families. Tennessee (1987 Tenn. Pub. Acts, Chap. 348) created a committee to review state policies on children and youth and to study problem areas, including emotional illness, alcohol and drug abuse, and homelessness.

In recent years, Indiana (1986 Ind. Acts, P.L. 21) and Nebraska (1986 Neb. Laws, L.B. 433) directed relevant state agencies to make recommendations on ameliorating the lack of coordinated service delivery to children. Washington (1986 Wash. Laws, Chap. 274) now requires the Department of Social and Health Services and the Superintendent of Public Instruction to coordinate services to children and youth. Other states have initiated pilot projects. South Carolina (1983 S.C. Acts, Act 151) established the South Carolina Continuum of Care Project for Emotionally Disturbed Children. New Hampshire (1985 N.H. Laws, Chap. 317) requires the Departments of Education and Health and Human Services to establish a demonstration program of community-based educational and residential facilities.

Service Needs and Components of Care. At least 23 states have passed legislation addressing distinct needs or populations relative to mental health care for children and youth. To begin with, at least 10 states have addressed the need for residential programs. For example, Arizona (1979 Ariz. Sess. Laws, Chap. 210) provides for joint responsibility between school districts and state agencies for the residential placement and treatment of emotionally disturbed children. Other states that have moved in this area include Indiana, Louisiana, Maine, Maryland, New Hampshire, New York, North Carolina, Oklahoma and Washington.

Florida, Hawaii and Maine have passed legislation targeting certain groups within the larger group of children and youth in need of mental health services. Hawaii (1984 Hawaii Sess. Laws, H.R. 395) required a study on the feasibility of establishing intermediate nursing facilities for the care of severely multiple-handicapped children. Maine (1982 Me. Laws, Chap. 307) developed a statewide coordinated delivery system for preschool handicapped children. Another state, Massachusetts (Mass. Gen. Law Ann. Ch. 71B, §12A-12C) has targeted the special

population of youth who are "aging-out" of the children and youth service system. The law provides that such persons are eligible to receive "transitional services" designed to assist them in achieving self-sufficiency.

At least four states have targeted prevention of substance abuse. Arizona (Ariz. Rev. Stats. §15-712), Colorado (Colo. Rev. Stat. §122.1.110, 1985), Pennsylvania (1986 Pa. Laws, Act 117) and Rhode Island (1986 R.I. Pub. Laws, Chap. 412) require that a program on the dangers of substance use/abuse be taught in grades K-12.

At least three states, Illinois (1983 Ill. Laws, P.A. 699), Oregon (1983 Or. Laws, Chap 731) and Texas (1981 Tx. Gen. Laws, Chap. 572) have established early intervention programs. Texas established an Interagency Council on Early Intervention Services, charged with developing and implementing a state plan for early childhood intervention services, as well as an Early Childhood Intervention Program, charged with coordinating efforts between various state agencies involved in identifying developmentally delayed children. California (1986 Cal. Stats, Chap. 1472 and Chap. 1551) and Connecticut (1985 Conn. Acts, P.A. 402) established grant programs for school-based screening systems. Maine (1985 Me. Laws, Chap. 56) mandated the development of an interdepartmental plan for statewide preventive intervention.

Moreover, several states have turned attention to suicide prevention. In 1987, at least five states addressed the teen suicide issue: Connecticut (1987 Conn. Acts, P.A. 107), Illinois (1987 Ill. Laws, P.A. 85-297), North Carolina (1987 N.C. Sess. Laws, Chap. 873), and Viriginia (1987 Va. Acts, H.J.R. 312). In recent years, California (1985 Cal. Stats, Chap. 1286) required the development of a five-year youth suicide prevention program, while Maryland (1986 Md. Laws, H.J.R. 47/S.J.R. 7) called for a task force on suicide prevention and established a youth suicide prevention program through the Department of Education (1986 Md. Laws, Chap. 122).

In 1987, six states addressed the need for inpatient facilities or programs for mentally ill children and youth, separate from adults: California (1987 Cal. Stats., Chap. 1107), Florida (1987 Fla. Laws, Chap. 209), Hawaii (1987 Hawaii Sess. Laws, H. R. 274), Montana (1987 Mont. Laws, Chap. 549), Ohio (1987 Vol. 142, Ohio Laws, H. 499), and Wyoming (1987 Wyo. Sess. Laws, Chap. 153).

During the 1986 session, at least five states, Arizona (1986 Ariz. Sess. Laws, Chap. 182) Colorado (1986 Colo. Sess. Laws, Chap. 211), Connecticut (1986 Conn. Acts, P.A. 311), Kentucky (1986 Ky. Acts, Chap. 423) and Tennessee (1986 Tenn. Pub. Acts, Chap. 836) passed legislation concerned with the voluntary or involuntary commitment of minors. Moreover, Oregon (Or. Laws, Chap. 525) recently authorized minors to receive outpatient care without parental consent.

Funding. At least nine states, Arizona, California, Florida, Maine, Minnesota, Nevada, New York, Oregon and Wyoming, have passed legislation that addresses itself to paying for or specifically providing services to children and youth. New York (1984 N.Y. Laws, Chap. 305) authorized grants to nonprofit organizations to cover the costs incurred in developing residential facilities for children and youth. Wyoming (Wyo. Stat. §21.13.315, (1983)) established a mechanism for state payment of residential and educational costs of court-ordered placements of children in private facilities or group homes.

FUTURE TRENDS AND IMPLICATIONS

Although children's mental health services have improved dramatically in the past 15 years, these systems continue to have major gaps and barriers. Even with the significant growth of non-residential alternatives, children are still unnecessarily confined, primarily due to a lack of available or appropriate alternatives to inpatient care. There has been a tremendous growth in mainstream education of children with emotional or mental problems, but the average state only serves two-thirds of the special education needs (6, p. 6). Involvement of the family in the

treatment process remains minimal despite the evidence that suggests a high percentage of children with mental illness are from multi-problem families. Early intervention and prevention programs, perhaps the most effective and efficient mental health services, are overburdened and usually the first to be unfunded when financial crises arise. And finally, there remain countless children with severe emotional problems who are not obtaining the services they so desperately need.

While the federal government has played a more active role in children's mental health during the recent years, continued support is vulnerable in light of the current fiscal situation. It will become increasingly important for states to make the most efficient use of available resources.

State legislatures and other governmental bodies, foundations and other private sector institutions, and mental health systems are attempting to produce positive changes, despite the current fiscal crisis in many states, in the delivery of mental health services to children and youth. A swell of legislation within the states during recent years clearly indicates increased attention to children and efforts to improve the system. Private foundations, such as the Edna McConnell Clark Foundation, have joined forces with policymaking organizations, such as the National Conference of State Legislatures and the National Governors' Association, to improve services through policy and programmatic decisions. Innovative programs, such as the Homebuilder's program in Tacoma, Washington, which provides crisis intervention in the home, are combining creative measures to produce successful and cost-effective treatment of emotionally disturbed children and their families.

Despite recent progress, much remains to be done. Children's mental health is a pay now or pay later problem. The problems of children with emotional disorders, for the most part, get worse without treatment. Those unserved as children grow up to be disabled adults, requiring extensive and expensive care. To stem this relentless and ever-growing need for mental health services among children and adults, policymakers and providers should focus on:

- Developing a continuum of care to address the changing and varied mental health needs of children and their families;
- Coordinating and integrating the delivery system so that those children and families in need can easily access the system; and
- Involving families in the treatment process and attempting to maintain children in their own home.

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TECHNICAL ASSISTANCE PROGRAM TAPES AND BACKGROUND MATERIAL

Available through the NCSL Mental Health Project are background materials relating to mental health services for children and youth. The packet includes a summary of select state legislation, a discussion of model programs, a bibliography, and other relevant information.

If you wish to receive the background information on mental health services for children and youth, please copy, complete, and return the form below to the Mental Health Project, NCSL, 1050 17th Street, Suite 2100, Denver, CO 80265.

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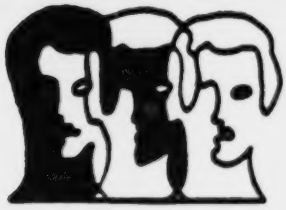

MENTAL HEALTH PROJECT

PROJECT OVERVIEW

In June 1986, the National Institute of Mental Health (NIMH), U.S. Department of Health and Human Services, awarded a contract to the National Conference of State Legislatures (NCSL) to conduct technical assistance programs for state legislators on mental health policy issues from 1986 through 1989.

The goal of NCSL's Mental Health Project is to improve the decision-making ability of state legislators on mental health policy by providing specific assistance to chosen states and disseminating information regarding mental health issues.

During this three-year program, the Mental Health Project will respond to specific issue and format needs of legislators. Under the guidance of the Mental Health Advisory Committee, which is composed of legislators and other persons with mental health experience, Project staff will obtain assistance from expert consultants and state policymakers to provide a variety of services to states, including testimony, special workshops and seminars, and individualized assistance.

Based upon input from the state legislatures, five states will be chosen each year to receive technical assistance on state-specific mental health issues. Along with the programs, the Mental Health Project will develop background materials, audio tapes, and various publications for each issue area. These materials are available free of charge to requesting parties.

The mental health technical assistance program will be offered to the following states during 1987-88:

Illinois	Develop recommendations about community services for mentally ill and developmentally disabled persons
Iowa	Study civil commitment laws to determine whether they should be revised and study the availability of community resources and funding for mental health services
Maine	Review overcrowding at two state inpatient facilities and make recommendations to improve conditions or ensure appropriate community alternatives
Montana	Improve conditions and services at the state hospital to ensure proper care and treatment of patients
Washington	Review overall mental health system, with emphasis on community residential services, involuntary commitment, and funding incentives

The Health and Mental Health Program Manager is Rebecca T. Craig, who may be contacted at NCSL's Denver office (303/623-7800). The acting federal project officer is Vernon James, National Institute of Mental Health (301/443-3606).

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